

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
SPECIFICALLY VERIFICATION OF **COVID-19 VACCINATION STATUS**

Patient Name: _____

Patient Date of Birth: _____ Patient SS# _____
(Optional)

I _____ hereby authorize
(Patient)

Show Me Vax
Missouri's Immunization Information System

To disclose specific health information from the records of the above-named Patient to:

The Director of Health of the City of St. Louis and/or his designee; and The
Director of Personnel of St. Louis and/or his designee; and the patient's
Appointing Authority and/or his designee.

For the specific purpose(s): of verifying the COVID-19 vaccination status of the Patient

**Specific information to be disclosed: COVID-19 Vaccination status of the Patient,
including date of vaccination or vaccinations, and type of vaccine administered to
Patient. No further disclosures are authorized by signing this authorization.**

The City of St. Louis, its agents, and employees will comply with the confidentiality provisions of the Americans with Disabilities Act ("ADA") with regard to all information collected pursuant to this authorization, as well as the Privacy Rule of HIPAA.

I understand that I may revoke this authorization at any time. If I want to revoke this authorization, I have to do it in writing and send it to the above specified Recipient who is authorized to receive the health information and/or to the person(s) who is authorized to disclose the health information under this authorization form. My revocation of this authorization, though, will not apply to any information that has already been disclosed before I have effectively revoked this authorization. Also, my revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date or event: **Receipt of response of Show Me Vax or response of Other State Department of Health.** If I fail to specify an expiration date or event, this authorization will expire in six (6) months.

I understand that any information disclosed under this authorization to above-related Recipient might not be protected by state or federal confidentiality or privacy laws or rules and could be re-disclosed by the Recipient.

I understand that I am not authorizing a release of any other medical information including information relating to HIV infections, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, or behavioral or mental health services, and therefore this authorized disclosure will NOT include that information.

I understand that neither any Covered Entity of the City of St. Louis nor any of its affiliated health care providers can make me sign this authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility on any health insurance plan, unless the federal Privacy Regulations allow it.

A photocopy of this authorization may be used in place of the original.

Signature of Patient or Personal Representative

Date

Print name of Patient or Personal Representative

If signed by a Personal Representative, provide relationship and/or authority to act for Patient along with attached copies of legal documentation of that authority if the person is of legal age.

Rev. 09/21/21